GIFT of LIFE MICHIGAN
ORGAN AND TISSUE DONATION

The power to heal lives.℠

IN SUPPORT OF SENATE BILL 592

Senate Bill 592 seeks to expand the definition of location where deceased donor organs may be recovered for the purposes of transplant, therapy, education and research to include a facility operated by the federally designated organ procurement program. Gift of Life Michigan is that organization in the state.

THE ISSUE: The moment a patient is declared at a hospital, multiple items occur.

1) Per federal regulations, Gift of Life Michigan is contacted regarding the patient's demise. The process of organ donation, once death is declared, can take anywhere from 15-32 hours until recovery of organs.

2) The hospital has a real and pressing interest to vacate the bed, typically in the intensive care unit, for living persons who need critical care in order to save their life. In addition, recovery of organs at the donor hospital also requires use of an operating room at the hospital, again, setting aside living patients' needs for that of a deceased donor.

3) The family requires personal attention and the time necessary to process the tragic and often sudden news that their loved one has passed away and is a candidate for organ donation.

As a pilot, Gift of Life leased and began to operate two surgical recovery rooms at a hospital located in Southfield, Michigan, to replicate the experience at centers in Pennsylvania, Missouri and Colorado. The internationally presented abstract "Centralized Organ Procurement Organization Surgical Center: First 200 Brain Dead Organ Donor Transfer Experience" is attached for reference. This paper is seen as the most comprehensive overview of the various benefits of an organ procurement organization operated surgical center. Based on this report, New York, California, Ohio, Minnesota and Illinois are currently constructing centers along the same model.

COST CONTAINMENT: The 2013 median hospital procurement cost per donor was significantly lower ($p<0.05$) in the transfer population ($14,982) compared donor hospital facilitated brain dead cases ($19,890). The cost savings are a reflection of the economies of scale in having an operating room devoted to organ recovery, the ability to predict and contain costs related to room rental and use of supplies, and the benefit of having a dedicated team located at the center. Cost is important. As a not-for-profit organization, Gift of Life Michigan directly passes the savings on to Michigan transplant

centers. At Gift of Life, there has not been a rise in the organ recovery fee in over five years, whereas, nationally, fees collected by organ procurement organizations have risen steadily. Organ recovery fees are passed subsequently to insurance companies or to Medicare and Medicaid providers.

QUALITY OF SERVICE: According to the Scientific Registry of Transplant Recipients, in 2013, the national average of organs transplanted per donor was 3.3 and Gift of Life Michigan's average was 3.9. Recoveries at the pilot surgical center averaged 4.2 organs transplanted per donor. This is a significant increase and can be directly related to more lives saved (24 additional organs transplanted). The quality of the organs are higher due the factors outlined under cost containment: having recovery occur at an offsite facility ensures that organ recovery is the priority and happens in a timely manner; in addition, having a dedicated recovery space decreases risk and ensures proper supplies and staff support.

ACCESS TO CARE: The organ procurement organization operated surgical center guarantees that the donor hospital can concentrate on living persons' care. The donor family center under construction at the facility will also allow families time to be with their loved one, time that is typically not granted in a donor hospital. As is shown in the abstract, donor families experience improved satisfaction in service following transfer of their loved one to a surgical center.

The vision of a Gift of Life facility is quickly becoming a reality, at an unanticipated pace. Decisions were made in early summer to accelerate construction by focusing on only the surgical suites, rather than clinical office space and an educational space. This moved the timeline for completion of the center to March 2016. Rather than continue with pursuing an administrative rule change, the decision was made to ask for a legislative change.

Our Mission:

To maximize organ and tissue donation for transplantation through innovative programs and exceptional service.

Our Vision:

To be an internationally recognized leader in all aspects of organ and tissue donation.

The power to heal lives.

CENTRALIZED ORGAN PROCUREMENT ORGANIZATION SURGICAL CENTER: FIRST 200 BRAIN DEAD ORGAN DONOR TRANSFER EXPERIENCE

Authors: **R Pietroski, P Lange, N Houghton, A Kowalczyk, T Trost, J Frey, N Obaseki, M Tudor**, Gift of Life Michigan

Purpose:

To objectively evaluate the clinical and business case of an OPO leased space involving dedicated intensive care and surgical center areas, involving 200 brain dead organ donor transfers for routine organ procurement for transplant, as a demonstration project for an OPO stand alone facility.

Methods:

Operational, financial, logistical and donor family satisfaction (DFS) metrics among 200 brain dead donors transferred to a leased space, stand-alone OPO surgical center were contrasted to a population of brain dead organ donors performed under the traditional donor hospital model where organ recovery takes place in multiple facilities where brain death was declared.

Results:

Between August 6, 2010, and December 30, 2013, 200 brain dead donors were transferred to a centralized OPO intensive care and surgical center. The first 12 brain dead case transfers in 2010 were purposely limited to abdominal alone donors, which accounted for a lower weighted mean rate of OTPD observed in the first year in contrast to the 4.2 OTPD in 2013 that included 149 kidneys, 70 livers, 68 lungs, 31 hearts, 8 pancreata, and 5 intestines. The 2013 median hospital procurement cost per donor was significantly lower ($p<0.05$) in the transfer population ($14,982) compared donor hospital facilitated brain dead cases ($19,890). Clinical skill set development of advanced practice OPO intraoperative donor management procurement coordinators allowed for the replacement of variable anesthesiology staffing in early 2013. This staffing change elevated, and nearly doubled, the percent and volume of brain dead donor transfer cases from the previous year. Weighted mean Donor Family Satisfaction (DFS) scores from 2011 to 2013 are statistically equivalent for the brain dead donor transfer group (4.88; n=95), when compared to the weighted mean DFS scores among brain dead donor cases performed at the donor hospital (4.89; n=228), and for hospital facilitated donation after circulatory death cases (4.93; n=110).

TRANSFER DONOR METRICS	2010	2011	2012	2013
Total Brain Dead Donors for Period	207	211	203	200
Brain Dead Donor Transfers (%)	17 (8.2%)	63 (29.9%)	41 (20.2%)	79 (39.5%)
Median Cost per Donor Procurement	$11,435	$14,262	$16,407	$14,982
Mean Surgical Center OTPD	3.0	3.8	3.8	4.2
Mean DFS; 5-point Likert Scale (n)	Not Done	4.73 (20)	4.96 (30)	4.90 (45)

Conclusion:

A centralized OPO operated intensive care and surgical center model for donor transfer demonstrates the ability to increase OTPD, reduce direct procurement costs and sustain donor family satisfaction as compared to the traditional hospital based donor procurement model. A total cost savings associated with the study period was $981,600, which allowed OPO organ acquisition charges to remain unchanged for four years in row. This demonstration project has also allowed the OPO to accurately conduct a pro forma and ROI for a $12.3 M facility build out to achieve further economies of scale and scope.

GIFT of LIFE MICHIGAN
ORGAN AND TISSUE DONATION